DIVISION OF LICENSING PROGRAMS VIRGINIA DEPARTMENT OF SOCIAL SERVICES

RENEWAL APPLICATION FOR A STATE LICENSE TO OPERATE AN ASSISTED LIVING FACILITY

This application shall be signed by the individual responsible for the operation of the assisted living facility (ALF) or, if the facility is to be operated by a board, by an officer of the board, preferably the chairman. The completed application shall be filed prior to the expiration of the current license and, to assure timely processing, should be filed at least 60 days before the current license expires. Answer each question on the application, i.e., do not refer to previous applications on this form.

Application is hereby made for a license to operate an assisted living facility pursuant to Chapters 17 and 18, Title 63.2 of the Code of Virginia.

Name of Assisted Living Facility: _____ Telephone Number: _____

Facili	ity Location:				
		Street or Route Number	City	State	Zip Code
Maili	ing Address:				
		Street, Route or Box Number	City	State	Zip Code
In ma	king this application	on, I state that:			
1.	I am in receipt facilities.	t of and have read a copy of the licensis	ng statute and the standards and	l regulations applica	able to assisted living
2.	I certify that it them if I am so	is my intent to comply with the aforement licensed.	tioned standards, regulations and	statutes and to rema	in in compliance with
3.	review of recorthat, following	sion to the Department of Social Service surrounding this application and any star ds, and interviews of my agents, employed licensure, authorized agents of the Dep ompliance with standards and regulations a	tement made herein, including f es, and any adult or other person wartment will make announced a	inancial status, insp within my custody o and unannounced v	ection of the facility r control. I understand
4.	I understand that	at I will be required to supply reports from	the local health department and	appropriate fire prev	rention officials.
5.		nat an application for a license is subject I have appeal rights that are explained in			event of denial, it i
6.	duties, make fa	it is a misdemeanor for any person to into lse or untrue reports with respect to the op- taining a license, or serve more persons th	peration of the facility, engage in	the operation of an	
7.		my knowledge and belief, all information is true and correct. I will supply true and			
			Date		
		Name of Applicant (Individual o	or Organization Applying for I	Licensure)	
By: _					
-		Signature	Applicant's Mailing Addre.	ss if different from	the ALF
	N	ame (Please Print)	City, State, Z	Zip Code	
	T	itle (Please Print)	Business Tel	ephone	
032.0	5-025/5 (Revised:	10/05)			

032-05-025/5 (Revised: 10/05)

_	I. GENERAL INFORMATION			_						
A.	Name of individual, partnership, corporation, limited liability company, unincorporapplying for the license:									
В.	Administration of the assisted living facility:									
	1. Name of the administrator:			_						
	2. Name of the designated assistant administrator, if any:			_						
C.	Number of persons now residing in the facility:									
	1. Residents: Male Female Total Residents	-								
	2. Family Members	-								
	3. Employees	-								
	4. Others (specify roles)	-								
	5. TOTAL									
	II. LICENSURE AND PROGRAM INFORMA (Attach additional pages if more space is needed.)	TION		_						
A.	Maximum number of residents license requested for:									
В.	Number of buildings license requested for:									
C.	Request for licensure level: (check applicable level)									
	I request licensure for residential living care only.									
	I request licensure for both residential living care and assisted living care	<u>.</u>								
D.	Specify the current number of residents assessed for:									
	Residential living care									
	Regular assisted living care									
	Intensive assisted living care									
	NOTE: The number of residents in these three categories should add up to the facil population.	ity's total cu	urrent resident							
Е.	Does the facility provide care for residents who:									
	are nonambulatory?	Yes	No							
	have mental illness or mental retardation or who are substance abusers?	Yes	No							
	have a history of aggressive behavior?	Yes	No							
	need the use of restraints?	Yes	No							
	have a serious cognitive impairment and cannot recognize danger or									

protect their own safety and welfare?

Yes _____ No ___

3.

4.

F.	Describe the special needs of the residents, such as skilled nursing treatments, special diets, assistance with medicatio rehabilitative services:								
G.	the j	re there been any changes in the purpose of the assisted living facility, the characteristics of the population served, program, the services provided or the physical plant since the facility's last license was issued (i.e., during the rent licensure period)? Yes No							
	If "y	yes," describe these changes:							
Н.	Des	cribe any changes planned for the future:							
	I	II. ADDITIONAL MATERIAL TO BE INCLUDED AS PART OF THE APPLICATION							
Α.	The	appropriate fee for application processing.							
В.		atement or chart regarding sponsorship of the assisted living facility and organization of the management staff, information showing who is responsible for policy, operation and management decisions.							
C.		opy of any rules, requirements or policies of the assisted living facility that have changed since the facility's last nse was issued. Attached Not Applicable							
D.	the livir	the applicant is a partnership, corporation, limited liability company, unincorporated association or public agency, names and addresses of (1) any agent empowered to act on behalf of the entity in matters relating to the assisted ag facility and (2) the following persons as applicable: (Specify the office or position held by each person. Place asterisk before the names of any officers or agents who are new since the last application.)							
	1.	For a partnership, all the General Partners.							
	2.	For a <u>corporation</u> , the officers of the corporation, including the president, senior vice-presidents; secretary, treasurer and any other officer empowered to act on behalf of the entity in matters relating to the assisted living facility.							

For a <u>limited liability company</u>, all the members and each manager.

For an <u>unincorporated association</u>, the officers of the board/association.

- 5. For a <u>public agency</u>, the person responsible for the overall operation of the agency and any agency personnel empowered to act on behalf of the entity in matters relating to the assisted living facility.
- E. When not submitted with a previous application, a copy of the documents required for a background check of the applicant, or if the applicant is a partnership, corporation, limited liability company, unincorporated association or public agency, a copy of the documents required for a background check of its officers and agents. (In regard to officers and agents, see Part D above for a list of positions for which a background check is required.) A background check consists of a criminal history record check through the Central Criminal Records Exchange and a sworn statement or affirmation. Please retain the originals of these documents, which must be seen by the Commissioner's representative prior to issuance of a license.

Renewal Application – ALF		

	IV. STAFF INFORMATION SHEET	
NAME OF FACILITY:	DATE:	

If there are 25 or fewer employees, each employee must be listed separately. If there are more than 25 employees, the number of employees in each position, working in the same building, on the same shift, may be indicated in the column "NAME." List the specific hours to be worked in the "Work Schedule." NOTE: First Aid and CPR should be marked only when a person has a *current* certificate issued as specified in the ALF standards.

be marked only when a person has a <i>cu</i>						WORK SCHEDULE						
NAME	POSITION	1 ST AID	CPR	MED ADMIN	BLDG	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Page 5 of 6

Renewal Application – ALF Staff Information Sheet (Continued) Page 6 of 6

		1 ST MED			WORK SCHEDULE							
NAME	POSITION	AID	CPR	ADMIN	BLDG	Mon	Tues	Wed	Thurs	Fri	Sat	Sun